House of Representatives

File No. 796

General Assembly

January Session, 2007

(Reprint of File No. 48)

Substitute House Bill No. 7055
As Amended by House Amendment
Schedules "A" and "B"

Approved by the Legislative Commissioner
May 7, 2007

AN ACT CONCERNING MEDICAL NECESSITY AND EXTERNAL APPEALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2008*) (a) No insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes in this state on or after January 1, 2008, shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for

the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

(b) The provisions of subsection (a) of this section shall not apply to any insurer, health care center, hospital and medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 2. (NEW) (*Effective January 1, 2008*) (a) No insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes in this state on or after January 1, 2008, shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results

as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

(b) The provisions of subsection (a) of this section shall not apply to any insurer, health care center, hospital and medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 3. Section 38a-478n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner. As used in this section and section 38a-478m, "health insurer" means any entity, other than a managed care organization, which delivers, issues for delivery, renews or amends an individual or group health plan in this state, "health plan" means a plan of health insurance providing coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12) and (13) of section 38a-469, but does not include a managed care plan offered by a managed care organization, and "enrollee" means a person who has contracted for or who participates in a managed care plan or health plan for himself or his eligible dependents.

(b) (1) To appeal a denial or determination pursuant to this section

an enrollee or any provider acting on behalf of an enrollee shall, not later than **[**thirty**]** sixty days after receiving final written notice of the denial or determination from the enrollee's managed care organization, health insurer or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization, health insurer or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in subdivision (2) of this subsection. If the Insurance Commissioner receives three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedural or diagnostic coding, the Insurance Commissioner may, on said commissioner's own motion, issue an order specifying how such managed care organization or utilization review company shall make determinations about such procedural or diagnostic coding.

(2) The filing fee shall be twenty-five dollars and shall be deposited in the Insurance Fund established in section 38a-52a. If the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner shall waive the enrollee's fee. The commissioner shall refund any paid filing fee to (A) the managed care organization, health insurer or utilization review company if the appeal is not accepted for full review, or (B) the prevailing party upon completion of a full review pursuant to this section.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity as defined in subsection (c) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such entity determines: (A) The individual was or is an enrollee of the managed care organization or

health insurer; (B) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee has exhausted all internal appeal mechanisms provided; (D) the enrollee has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization or health insurer and any other relevant provider.

(5) Upon completion of the preliminary review, the entity conducting such review shall immediately notify the member or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with the provisions of chapter 54.

(c) To provide for such appeal the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide for medical review under the provisions of this section. Such review entities shall include (1) medical peer review organizations, (2) independent utilization review companies, provided any such organizations or companies are not related to or associated with any managed care organization or health insurer, and (3) nationally recognized health experts or institutions approved by the commissioner.

(d) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider

acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's plan is fully insured, self-funded, or otherwise funded. If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization or health insurer shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization or health insurer to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

(2) Failure of the managed care organization or health insurer to provide information or notify the plan sponsor in accordance with subdivision (1) of this subsection within said five-business-day period or before the expiration of the **[**thirty-day**]** sixty-day period for appeals set forth in subdivision (1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service is a covered benefit under the applicable policy or contract, except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract, and (B) entitle the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing a medical necessity determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

(e) The commissioner shall accept the decision of the review entity

and the decision of the commissioner shall be binding.

(f) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The Healthcare Advocate shall coordinate the outreach program and oversee the education process.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2008*	New section
Sec. 2	*January 1, 2008*	New section
Sec. 3	*from passage*	38a-478n

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill requires insurers and HMO's to include a statutory definition of "medically necessary" and extends appeals timeframes which have no fiscal impact.

House "A" makes a minor change which has no fiscal impact.

House "B" changes various dates within the bill which also has no fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 7055 (as amended by House "A" and "B")*

AN ACT CONCERNING MEDICAL NECESSITY AND EXTERNAL APPEALS.

SUMMARY:

This bill prohibits insurers, HMOs, and other entities from issuing individual and group health insurance policies that do not contain a statutory definition of "medically necessary" or "medical necessity." For those insurers and HMOs that have entered into a federal court-approved class action settlement with physicians, which includes abiding by a similar definition of "medical necessity," the bill's prohibition does not apply until the settlement's expiration date (see BACKGROUND).

The bill extends timeframes for appealing to the insurance commissioner (i.e., external appeal) after a person has exhausted a managed care organization's (MCO), health insurer's, or utilization review company's internal grievance procedures. Under current law, after receiving a final written claim denial based on a lack of medical necessity or determination not to certify an admission, service, procedure, or extension of hospital stay, a person, or a medical provider acting with consent on his or her behalf, has 30 days to file an appeal with the commissioner. The bill extends this time period to 60 days. It also makes a conforming change.

*House Amendment "A" limits the bill's medical necessity definition requirements to health insurance policies covering (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents only, (5) limited benefits, and (6) hospital or medical services, including those issued by HMOs.

*House Amendment "B" changes the effective date of the medical necessity definition provisions from October 1, 2007 to January 1, 2008.

EFFECTIVE DATE: January 1, 2008, except for the appeal provision, which is effective upon passage.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

The bill prohibits insurers and HMOs from delivering or issuing for delivery any individual or group health insurance policy in Connecticut unless it contains the following definition:

> "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease; and (3) not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

BILL APPLICATION

Medically Necessary Provisions

The bill's medical necessity provisions apply to insurers, HMOs, hospital and medical service corporations, and other entities delivering, issuing for delivery, renewing, continuing, or amending individual or group health insurance policies in Connecticut beginning

January 1, 2008 that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents only, (5) limited benefits, or (6) hospital or medical services.

Appeal Provision

The bill's appeal provision applies to individual and group health insurance policies delivered, issued for delivery, renewed, or amended in the state that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) limited benefits, or (5) hospital or medical services, including those issued by HMOs.

BACKGROUND

Class Action Settlements

Aetna, CIGNA, Health Net, Prudential, Anthem/WellPoint, and Humana entered into settlement agreements that apply nationally with over 900,000 physicians and state and county medical societies in the class action lawsuits consolidated as *In re Managed Care Litigation* in the U.S. District Court for the Southern District of Florida. The settlements were approved at various times between 2003 and 2006. Other defendants, including PacifiCare, United, and Coventry, did not enter into settlement agreements with the physicians.

The lawsuits alleged that since 1990, these companies engaged in a conspiracy to improperly deny, delay, or reduce payment to physicians by engaging in several types of allegedly improper conduct, including failing to pay for "medically necessary" services in accordance with member plan documents. Under the terms of the settlement agreements, each company has agreed to use a specified definition of medical necessity. The settlements have expiration dates that vary by company. When they expire, the companies will no longer be bound to follow the definition contained in the settlements.

External Appeals

A person, or provider on his or her behalf, who has exhausted a health insurer's, MCO's, or utilization review company's internal appeal process may appeal to the insurance commissioner any claim

denial based on medical necessity or decision not to certify an admission, service, procedure, or extension of stay.

The appeal must include a general release from the person for medical records and a $25 processing fee, which the commissioner can waive for an indigent person. The company against which the appeal is filed must also pay a $25 fee. The commissioner assigns the appeal to an independent entity for review and a binding decision. The commissioner refunds (1) the company's fee if, after an initial review, the appeal is not accepted for a full review or (2) the prevailing party's fee after a full review is completed.

An insurer or MCO must provide the commissioner, enrollee, or provider certain appeal-related information within five business days of receiving a written request. Failure to do so subjects the insurer or MCO to a $100 fine for each day of violation. The information includes written verification that the plan is fully insured, self-insured, or otherwise funded.

If the plan is fully insured, the insurer or MCO must also send (1) written certification to the commissioner or designated review entity that the benefit or service appealed is covered; (2) written certification that the policy or contract is accessible electronically, along with clear and simple instructions on how to access it; or (3) a copy of the entire policy or contract between the enrollee and the MCO.

The insurer's or MCO's failure to provide information or notify the plan sponsor within the five-business-day period or before the appeal deadline, whichever is later as determined by the commissioner, (1) creates a presumption that the benefit or service is a covered benefit for purposes of accepting the appeal for full review and (2) entitles the commissioner to require the MCO to reimburse the Insurance Department for appeal-related expenses. The presumption established does not create or authorize benefits or services exceeding those in the person's policy or contract.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 0 (02/27/2007)